

December 29, 1997

EA No. 97-602

Mr. Michael B. Sellman, President
Maine Yankee Atomic Power Company
Bailey Point Road
Wiscasset, ME 04578

SUBJECT: NRC INTEGRATED INSPECTION REPORT 50-309/97-08 AND NOTICE OF VIOLATION

Dear Mr. Sellman:

On November 29, 1997, the NRC completed an inspection at your Maine Yankee reactor facility. The results of that inspection were discussed with Mr. W. Odell and others of your staff at an exit meeting held on December 9, 1997. The enclosed report presents the results of that inspection.

During the three-month period covered by this inspection period, your conduct of activities at the Maine Yankee facilities was safety focused. Plant maintenance activities were conducted to place the plant in a very good condition for the upcoming months. A quality assurance audit of your health physics organization was appropriate and timely.

However, difficulties associated with core capsule removal and falsification of fire watch rounds were examples where inadequate Maine Yankee management oversight resulted in performance deficiencies. Additionally, it was noted that the initial Maine Yankee oversight of site characterization field work was weak. With upcoming evolutions, such as system decontamination, that are unique or infrequently performed, Maine Yankee management oversight will be paramount to your success. This is particularly true of evolutions being performed by contractors.

The falsification of fire watch rounds, which occurred during a previous period, was determined to be a result of improper implementation of the fire protection plan by Maine Yankee. The lack of procedures for the implementation of compensatory fire watch rounds is a violation of NRC requirements.

A security program violation involved the failure to ensure that detection aids used to alert security force members posted in the assessment towers were being controlled and maintained as required by the NRC-approved Physical Security Plan (the Security Plan). This is of particular concern because the applicable security procedure was revised as part of a corrective action in response to similar events in 1991 and 1995.

Included in this report is closeout of an Unresolved Item involving the potential violation of 10 CFR 70.24, Criticality Accident Requirements. We have determined that your facility was in violation of this regulation in that you did not have in place either a criticality monitoring system for storage and handling of new (non-irradiated) fuel or an NRC-approved

exemption to the regulation.

Thus, as described in the inspection report, your facility was in violation of 10 CFR 70.24. Numerous other facilities have similar circumstances. The NRC has reconsidered this violation and concluded based on the information discussed in the report that, although a violation did exist, it is appropriate to exercise enforcement discretion for Violations Involving Special Circumstances in accordance with Section VII B.6 of the "General Statement of Policy and Procedures for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600. The bases for exercising this discretion are the lack of safety significance of the failure to meet 10 CFR 70.24; the failure of the NRC staff to recognize the need for an exemption during the licensing process; the prior NRC position concerning the lack of a need for an exemption; and finally, the NRC's intention to amend 10 CFR 70.24 through rulemaking to provide for administrative controls in lieu of criticality monitors.

Therefore, I have been authorized after consultation with the Director, Office of Enforcement, to exercise enforcement discretion and not issue a violation for this matter.

The violations cited in the enclosed Notice of Violation, and the circumstances surrounding the violations are described in detail in the enclosed report. Please note that you are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. The NRC will use your response, in part, to determine whether further enforcement action is necessary to ensure compliance with regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

Sincerely,

Original Signed by:

A. Randolph Blough, Director
Division of Nuclear Materials Safety

Docket No: 50-309

License No: DPR-36

Enclosure: NRC Inspection Report No. 50-309/97-08 and Notice of Violation

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Michael B. Sellman

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NOTICE OF VIOLATION

Maine Yankee Atomic Power Company
Brunswick, Maine 04011

Docket No. 50-309
License No. DPR-36

During an inspection conducted between September 8 and November 29, 1997, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violations are listed below:

- A. The NRC-approved Maine Yankee Atomic Power Station, Physical Security Plan (the Security Plan), Revision 24, dated November 20, 1996, Section 6.4.1, states, in part, that "... continuously manned fixed assessment positions are strategically located in the protected area for alarm assessment and compensatory measures for degraded perimeter intrusion detection system (PIDS)...". Each assessment position is equipped with a device which generates an audible and a visual alarm in the event of an intrusion through the PIDS.

Section 1.0 of the Plan states that written procedures shall be established, implemented, and maintained. Additionally, Section 4.3.2 of Security Procedure Number 15-204.1, Revision 1, dated May 9, 1997, titled "Assessment Positions," requires that during post turnover, the Assessment Position Officer will verify that no tampering of the reset button associated with the audible alarm has occurred.

Contrary to the above, on October 10, 1997, a security force member circumvented the reset button associated with the audible alarm in one of the assessment towers. This action limited the ability of the security force member (SFM) to immediately assess a postulated unanticipated intrusion in the protected area. This degraded condition continued for approximately six hours. During that time period, 5 additional SFM's failed to perform a complete post turnover check, as required by the above referenced procedure.

This is a Severity Level IV Violation. (Supplement III)

- B. Technical specifications, section 5.8.2.f, required written procedures for fire protection program implementation. The Maine Yankee procedure, 19-5, Impairments to Fire Protection Systems, section 4.2.1, required compensatory measures to be established for impairments to fire protection plan fire protection systems. Maine Yankee implemented a roving fire watch program as a compensatory measure for degraded fire protection plan fire protection systems.

Contrary to the above, the instructions for implementation of the roving fire watch program implemented by Maine Yankee were not documented by procedures. Instead, Maine Yankee used a training lesson plan and a series of memos to implement the program. Inadequate implementation of the roving fire watch program resulted in several instances of rounds not being performed.

This is a Severity Level IV violation (Supplement I).

Pursuant to the provisions of 10 CFR 2.201, Maine Yankee Atomic Power Company is hereby required to submit a written statement of explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region I, and a copy to the NRC Resident Inspector at the facility that is the subject of this Notice, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previously docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in the Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without reduction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at King of Prussia, PA
on _____ day of December, 1997

U. S. NUCLEAR REGULATORY COMMISSION
REGION I

Docket No: 50-309

License No: DPR-36

Report No: 50-309/97-08

Licensee: Maine Yankee Atomic Power Company (MYAPC)

Facility: Maine Yankee Atomic Power Station

Location: Bailey Point
Wiscasset, Maine

Dates: September 8, 1997 to November 29, 1997

Inspectors: Richard Rasmussen, Senior Resident Inspector
Division of Reactor Projects

Paul Frechette, Physical Security Inspector
Division of Reactor Safety

Edward King, Physical Security Inspector
Division of Reactor Safety

Approved by: A. Randolph Blough, Director
Division of Nuclear Materials Safety

EXECUTIVE SUMMARY

Maine Yankee Atomic Power Company NRC Inspection Report 50-309/97-08

This integrated inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers a three-month period of resident inspection; in addition, it includes the results of an announced inspection by regional physical security inspectors.

Operations

The reactor plant and spent fuel pool cooling systems were placed in the desired condition for the upcoming months. Maine Yankee initiated actions to analyze and prepare for cold weather. Maintenance activities were completed and heating systems were functioning properly. The inspector did not identify any further areas of concern for cold weather. (Section O1.1 and 2.1)

Maintenance

Pre-evolution planning and appropriate radiological oversight resulted in the successful removal of the incore instruments. This evolution, which had potentially significant radiological consequences, was performed safely and in accordance with the procedure. (Section M1.1)

Initial oversight of site characterization activities by Maine Yankee was weak. The stop work imposed by Maine Yankee was appropriate to assure minor issues were adequately addressed and corrected. Communication issues were addressed and Maine Yankee personnel were assigned responsibility to monitor the site characterization. Issues identified by outside parties and agencies were being documented and addressed. Environmental sampling was being conducted in accordance with the procedures. (Section 2.1)

Engineering

The spent fuel pool heat-up test was an appropriate verification of the spent fuel pool heat-up rate. The procedure was well written and was properly approved. The test was performed and data was recorded as required by the procedure. (Section E2.1)

A weak procedure, poor procedure adherence, and inadequate planning for the capsule removal resulted in the evolution taking over twice as long as required. However, due to the relatively low dose rates in the work area the additional radiation exposure was not significant. The radiological controls and oversight implemented by health physics were excellent and resulted in the completion of the job with no exposure or contamination concerns. (Section E2.2)

Plant Support

The audit of health physics was a notable effort by Maine Yankee to identify and prevent issues similar to those which occurred at a similar facility undergoing decommissioning. The audit was thorough and the issues were appropriately accepted for resolution. (Section R7.1)

The staffing of the emergency response organization has been adequately managed and maintained throughout the reduction of personnel at Maine Yankee. A training drill was an effective tool to assure new personnel were familiar with their positions and emergency plan procedures. (Section P5.1)

The inspectors determined that, except for the violation associated with the detection aids, the licensee was conducting its security and safeguards activities in a manner that protected public health and safety. The Security Program, as implemented, met the licensee's commitments and NRC requirements. (Section S)

The falsification of fire watch rounds was determined to be a result of improper implementation of the fire protection plan by Maine Yankee. The lack of procedures for the implementation of compensatory fire watch rounds is a violation of NRC requirements. (Section F4.1)

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Report Details

Summary of Plant Status

Throughout the inspection period Maine Yankee remained in the decommissioning mode. Activities during the period focused on safe maintenance of the spent fuel, reorganization of the facility staff, revision of site procedures, including technical specifications and the emergency plan, and performance of the site characterization.

I. Operations

O1 Conduct of Operations

O1.1 General Comments (71707)

Using Inspection procedure 71707, the inspector conducted reviews of ongoing plant operations. Several major activities were completed to put the plant in the condition desired for the upcoming months. The spent fuel pool rerack project was stopped, and the final condition was analyzed as acceptable. Primary component cooling water was restored as the normal cooling supply to the spent fuel pool heat exchanger. The temporary secondary component cooling water hoses were removed. The incore radiation detection instrumentation was removed, the upper guide structure was installed, and the reactor head was set in place. The refueling cavity was drained and the fuel transfer canal blank flange was installed.

O2 Operational Status of Facilities and Equipment

O2.1 (Closed) LER 97-05, Cold Weather Preparations

a. Inspection Scope (71714)

The inspector reviewed the preparations made by Maine Yankee for cold weather. The inspector also independently toured the facility to look for areas of concern.

b. Observations and Findings

With the plant in the shutdown condition, the heat generation within the facility is greatly reduced. Because the spent fuel pool island has not yet been developed, Maine Yankee intends to heat the entire facility this winter. To assure proper implementation of the cold weather preparations, a senior member of the operations department was assigned as a lead and focal point of the project. As a result of brainstorming sessions, 54 issues were identified. These issues were tracked and the resolutions were documented. As of November 18, 1997, all but eight actions were completed. The remaining items, several of which were efficiency improvements, were being tracked and were manageable.

The auxiliary heating system at Maine Yankee uses oil burning boilers to produce steam. The steam is routed to radiators throughout the plant. Prior to the onset of cold weather, Maine Yankee performed maintenance activities to prepare the auxiliary boilers and steam heating system for winter.

One area of concern was the containment building. Freezing in the containment building could result in freezing and damage to the fuel transfer canal, which is a spent fuel pool boundary. To address this concern Maine Yankee will heat the containment using the normal containment heating unit. Maine Yankee has estimated that the installed heater has adequate capacity to preclude freezing. Several areas within containment are monitored for temperature by the plant computer. The computer readings and alarms can be read by the operators in the control room. Additionally, Maine Yankee is preparing to install a blank flange on the spent fuel pool end of the transfer canal. This flange will prevent the tube from filling with water and will further eliminate the risk due to freezing.

A previous area of concern in cold weather was the intake structure. Licensee Event Report (LER) 97-05 reported the potential for freezing due to a loss of power during extreme cold periods. Although this potential still exists, the consequences are greatly reduced with the plant shutdown and defueled. The heat up rate of the spent fuel pool allows adequate time to address any resultant problems from a loss of power to the intake structure. Additionally, operators monitor temperature on a once per shift basis normally, and once every four hours during periods with temperature less than 20° F. Therefore, LER 97-05 is closed.

c. Conclusion

Maine Yankee initiated actions to analyze and prepare for cold weather. Maintenance activities were completed and heating systems were functioning properly. The inspector did not identify any further areas of concern for cold weather.

08 Miscellaneous Operations Issues

08.1 Review and Closure of Open Issues

Previously opened issues related to systems or components no longer required to be maintained in the current plant condition were reviewed. The issues below were determined to no longer have any safety or regulatory significance with the plant in the decommissioning mode. The following list of unresolved items (URIs), LERs, and follow-up of previously cited violations (VIOs) were reviewed and are closed.

50-309/94-04-01	URI	Erosion Corrosion Database Deleted
50-309/94-14-02	URI	MOV Pressure Locking and Thermobinding
50-309/95-01-02	URI	Inoperable Fire Protection Ventilation Dampers

50-309/95-07-02	URI	Potential Overpressurization of CCW System
50-309/95-10-01	VIO	Design Control Weaknesses
50-309/95-12-01	URI	Control Room HVAC Filter Flow Surveillance Testing
50-309/95-12-02	URI	Evaluation of Freon Relief Valves Near Breathing Air Suction
50-309/95-02-00	LER	Cracked CAM Followers in General Electric SBM Switches
50-309/96-05-01	VIO	Design Basis Documentation not Maintained up-to-date
50-309/96-08-03	URI	Emergency Diesel Generator Room Damper Tornado Design
50-309/96-12-03	IFI	Documentation of Air Balance Surveillance Testing
50-309/96-14-02	URI	Testing of HPSI Pumps and Valves
50-309/96-14-04	URI	Safety-Related Logic Circuit Testing Update
50-309/96-16-01	URI	Technical Specification Interpretations
50-309/96-16-02	URI	Post Trip Reviews
50-309/96-16-03	URI	Emergency Operation Procedures
50-309/96-16-05	URI	Standby Power Meters not Calibrated and Periodically Tested
50-309/96-16-07	URI	Containment Cleanliness After Outage
50-309/96-16-08	URI	SER Conditions Satisfied but not Documented
50-309/96-16-09	URI	MSL Rupture Analysis Errors and Inconsistencies
50-309/96-16-10	URI	Lack of a Documented Process to Demonstrate Code Capability
50-309/96-16-11	URI	CS System and the CCW Systems
50-309/96-16-12	URI	CCW and RHR Heat Exchanger
50-309/96-16-13	URI	RHR Heat Exchanger Thermal Transient

50-309/96-16-14	URI	Electrical Calculations for EDG
50-309/96-16-15	URI	EQ Issues
50-309/96-16-16	URI	FSAR Discrepancies
50-309/96-16-17	URI	Reportability of CCW Operations Different than FSAR Design
50-309/96-16-20	URI	Emergency Diesel Generator Electrical Loading
50-309/96-16-24	URI	Control Room Ventilation Testing Deficiency
50-309/96-16-25	URI	Weaknesses in the Erosion/Corrosion Program
50-309/95-17-00	LER	LSI-S-63 Leaking from Inlet Flange
50-309/96-05-00	LER	PAB Masonry Wall Seismic Deficiency
50-309/95-11-01	LER	Seat Ring Degradation in Contromatics Butterfly Valves
50-309/96-16-00	LER	Failure to Maintain Short Term Corrective Action
50-309/96-19-00	LER	SCC Standby Pump Autostart Pressure Switch Inoperable
50-309/96-22-00	LER	Containment PCC Piping Design Inadequate
50-309/96-23-00	LER	RWST Level Transmitter Uncertain Qualified Life
50-309/96-25-00	LER	RCS Emergency Vent Valves Inoperable
50-309/96-26-00	LER	EQ of Cables/Connectors Inside CTMT May Not Meet Requirements
50-309/96-27-00	LER	FN-44 A&B Declared Inoperable
50-309/96-28-00	LER	Inadequate Emergency Feedwater Pump Check Valve Surveillance
50-309/96-20-00	LER	High Pressure Safety Injection Pump Auto-Start Wire Found Cut
50-309/96-31-00	LER	Plant Trip During Reactor Protection System Surveillance
50-309/96-34-00	LER	Inadequate Cable Separation For Post Accident Hydrogen

Monitors

50-309/96-36-00	LER	Entry into 3.0.A When Exhaust Fan Shut Down
50-309/97-02-01	IFI	Revised Separation Criteria
50-309/97-05-03	VIO	Failure to Reestablish Pump Baseline Values
50-309/97-05-04	VIO	Test Control - Incorrect Acceptance Criteria
50-309/97-05-05	VIO	Implementation of Code Alternative Without NRC Approval
50-309/96-42-00	LER	Lack of Thermal Relief Valves for Several Heat Exchangers
50-309/96-39-00	LER	Both Emergency Diesel Generators Declared Inoperable
50-309/96-40-00	LER	Inadequate Surveillance Procedure for RTB Actuation
50-309/96-43-00	LER	Generic Letter 96-01 Identified Surveillance Issues
50-309/97-02-00	LER	PCC/SCC Vacuum Relief Valve Testing
50-309/97-03-00	LER	Leaking Fuel Pins Identified in Westinghouse Fuel Assemblies
50-309/97-04-00	LER	RCS Loop Fill Header MOV Overpressure
50-309/97-10-00	LER	Steam Generator Tube Deficiency Issues
50-309/96-43-01	LER	GL 9601 Testing Issues
50-309/93-10-00	LER	Surveillance testing of ECCS Subcomponents

O8.2 (Closed) - Unresolved Item 50-309/97-05-07: Failure to meet requirements of 10 CFR 70.24 for new fuel criticality monitors.

This issue involved the failure to have in place either a criticality monitoring system for storage and handling of new (non-irradiated) fuel or an NRC-approved exemption to this requirement contained in 10 CFR 70.24. 10 CFR 70.24 requires that each licensee authorized to possess more than a small amount of special nuclear material (SNM) maintain in each area in which such material is handled, used, or stored a criticality monitoring system which will energize clearly audible alarm signals if accidental criticality occurs. The purpose of 10 CFR 70.24 is to ensure that, if a criticality were to occur during the handling of SNM, personnel would be alerted to that fact and would take appropriate action.

Most nuclear power plant licensees were granted exemptions from 10 CFR 70.24 during the construction of their plants as part of the Part 70 license issued to permit the receipt of the initial core. Generally, these exemptions were not explicitly renewed when the Part 50 operating license was issued, which contained the combined Part 50 and Part 70 authority. In August 1981, the Tennessee Valley Authority (TVA), in the course of reviewing the operating licenses for its Browns Ferry facilities, noted that the exemption to 10 CFR 70.24 that had been granted during the construction phase had not been explicitly granted in the operating license. By letters dated August 11, 1981, and August 31, 1987, TVA requested an exemption from 10 CFR 70.24. On May 11, 1988, NRC informed TVA that "the previously issued exemptions are still in effect even though the specific provisions of the Part 70 licenses were not incorporated into the Part 50 license." Notwithstanding the correspondence with TVA, the NRC has determined that, in cases where a licensee received the exemption as part of the Part 70 license issued during the construction phase, both the Part 70 and Part 50 licenses should be examined to determine the status of the exemption. The NRC view now is that unless a licensee's licensing basis specifies otherwise, an exemption expires with the expiration of the Part 70 license. The NRC intends to amend 10 CFR 70.24 to provide for administrative controls in lieu of criticality monitors.

The NRC has concluded that a violation of 10 CFR 70.24 existed. The NRC has also determined that numerous other licensees have similar circumstances that were caused by confusion regarding the continuation of an exemption to 10 CFR 70.24 originally issued prior to issuance of the Part 50 license. After considering all the factors that resulted in these violations, the NRC has concluded that while a violation did exist, it is appropriate to exercise enforcement discretion for Violations Involving Special Circumstances in accordance with Section VII B.6 of the "General Statement of Policy and Procedures for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600.

O8.3 (Closed) LER 93-08-00, Emergency Core Cooling System (ECCS) Valves Found Unlocked

LER 93-08-00, ECCS Valves Found Unlocked, reported 19 valves associated with the service water system that were not locked. This was due to an oversight in the locked valve program, and all of the valves were in the correct positions. The valves were locked and the controlling procedures were revised. The inspector reviewed the service water system alignment and found no discrepancies. This item is closed.

O8.4 (Closed) LER 93-12-00, Control Room Ventilation Trains Inoperable Due to Preventative Maintenance

Maine Yankee reported that quarterly maintenance of the control room ventilation system resulted in both trains of control room ventilation being inoperable for short periods of time. Amendment 146 of the technical specifications was made to accommodate this problem. This LER is closed.

O8.5 (Closed) IFI 50-309/97-01-01, Spill of 1300 Gallons Through Pump Packing

Section O4.1 of NRC inspection report 50-309/97-01, documented instances of weak performance in operations which lead to a spill of approximately 1300 gallons of water to the spray pump sump. Subsequently, violation VIO 50-309/97-03-01, was issued to document similar performance issues. Therefore, IFI 50-309/97-01-01, is closed and corrective actions will be tracked by the above violation.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Incore Instrument Removal

a. Inspection Scope (62707)

In preparation for setting the reactor head back on the vessel, Maine Yankee used maintenance procedure 6-02-4, Incore Detector Removal, to remove the incore radiation detectors. The inspector reviewed the procedure and observed portions of the evolution.

b. Observations and Findings

The incore instruments (ICI's) were used during power operation to map the reaction rates within the core to monitor fuel performance. The first section of the detectors that were exposed to the core were highly irradiated. After approximately 30 feet the contact radiation levels decreased to less than 50 mr/hour. The removal process maintained the first section of tubing under water in the reactor cavity. The remainder of the tubing, approximately 120 feet, was removed from the water and cut up into drums for disposal. The irradiated detector tips were cut up under water and placed into trash baskets. The trash baskets were transferred to the spent fuel pool for storage pending disposal.

Preparation for this evolution was excellent. Training was conducted which featured slides of actual ICI removals during previous outages. The training covered specific duties, lessons learned, radiological controls, safety concerns, and contingencies. A pre-evolution brief was conducted prior to each shift to discuss project status and radiological conditions.

The removal of the detectors was accomplished as planned. The removal required team work between a crane operator, tool handlers, cutter operators, and health physics technicians. Communications were clear and concise. Radiological oversight was appropriate and the job was completed within the estimated dose.

c. Conclusion

Pre-evolution planning and appropriate radiological oversight resulted in the

successful removal of the incore instruments. This evolution, which had potentially significant radiological consequences, was performed safely and in accordance with the procedure.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Site Characterization

a. Inspection Scope (80721)

In preparation for decommissioning, Maine Yankee was performing a detailed site characterization. This characterization will provide the basis for decommissioning activities and their associated costs. The inspector reviewed the site characterization plan, observed activities in the field, and obtained independent samples for analysis.

b. Observations and Findings

The site characterization was being performed by a contractor. A Site Characterization Plan which describes the characterization process was submitted by the contractor to Maine Yankee and approved. Additionally, procedures used by the contractor were reviewed and approved by Maine Yankee. The site characterization effort was being monitored by several prospective decommissioning contractors. Questions received from all personnel involved were being documented and resolved.

The site characterization plan focused on five areas: 1) Environmental Radiological Characterization; 2) Radiological Characterization of Surfaces and Structures; 3) Radiological Characterization of Systems; 4) Hazardous Material Characterization Survey; and 5) Background Study Plan. Site characterization work commenced the week of November 3, 1997. The contractor started with two teams, an environmental team and a systems team.

The environmental team performed several types of surveys to identify plant-related radionuclides in the local environment. Drive-over surveys were performed to look for areas above background. The drive-over surveys involved a gamma scan using a plastic scintillator detector. This detector was mounted to a four wheel drive truck, a four wheel drive all terrain vehicle, and in some cases a backpack. A global positioning system (GPS) receiver was used in conjunction with the surveys to mark the locations of the readings. The GPS readings were corrected for the inherent GPS inaccuracies through the use of a stationary receiver at a known location that produces a real time GPS correction factor. The GPS readings and survey data were recorded and stored in a computer.

The drive-over surveys were nearly completed for accessible areas. However, early snowfall in the area prohibited the completion of one area. Areas with elevated readings were marked in the field with surveyors flags and additional analysis will be performed to determine the cause of the readings. At the close of the inspection, the results of these surveys were still being analyzed.

Throughout the owner-controlled area, soil samples were being collected. The entire area was subject to sampling on a random basis. Additionally, the frequency of sampling was increased in areas suspected to contain plant-related materials or areas with visible or historic disturbance. Samples were taken less frequently in the remote and wooded areas of the property. Each sample location was marked with a stake. At each sample location, soil samples were taken to a depth of six inches and a micro-rem radiation reading was taken. Soil samples were sealed in plastic bags and controlled through a chain-of-custody program.

A large percentage of the area surrounding the plant is river and mud flats. At low tide the mud flats are extensive and are used by local residents for digging clams and worms. The characterization plan called for samples of the mud flats. An air boat was used to provide easy access for obtaining samples. Mud samples were taken on the flats all around the owner-controlled area, as well as across the river on the banks of Montsweag Island. Initially, samples were only taken to a depth of six inches. However, due to questions related to the basis for the six inches, a number of samples will be taken to eighteen inches.

In addition to the mud flat samples, sediment samples were taken from the river bottom near the discharge diffuser pipe. The discharge diffuser pipe is the effluent path for all normal plant discharges. As of the end of this inspection period, the soil, mud, or sediment samples had not been analyzed due to the laboratory preparation and procedures not being completed.

The inspector observed a portion of the field sampling and obtained independent samples at several locations. The inspector observed the technicians adequately documenting their surveys and samples and obtaining the samples in accordance with their sampling procedures. The results of the NRC analysis will be compared to the licensee results.

Systems and structures characterization work was also started. System surveys involved opening systems to check the internals for activity. The Maine Yankee work control system was being used to control work on plant systems. Mechanics were performing the physical work of opening systems and the contractor was performing the surveys. At the completion of the surveys, systems required to be functional were being restored and returned to operations.

Structures surveys involved scanning building floors, walls, and ceilings. One of the first buildings checked, the information center, was identified to have elevated areas of activity in the carpet. The identification of contamination in the information center was not expected because it is located outside of the protected area. The activity was investigated and found to be residue from a sample of a uranium-rich rock sample used in the information center for educational seminars. The activity was not related to plant operation. The contaminated carpet was removed and disposed of as radioactive waste. Structure surveys were ongoing at the end of the inspection period.

During the first several weeks of site characterization, the Inspector noted a lack of field oversight of sampling and surveying by Maine Yankee. The inspector raised this concern with Maine Yankee management who responded by increasing their level of oversight. On November 18, 1997, Maine Yankee quality assurance identified that required procedures were not in place for the performance of surveys of systems and structures. As a result, Maine Yankee issued a stop work order and required the contractor to perform a root cause analysis. Corrective actions included reviewing procedures, issuing missing procedures, training of personnel, and reperforming a percentage of the surveys completed without adequate procedures. Additionally, a communication plan was developed to assure better communications between Maine Yankee and the contractor. The actions required to resume work were completed and Maine Yankee released the hold on November 24, 1997.

c. Conclusion

Initial oversight of site characterization activities by Maine Yankee was weak. The stop work imposed by Maine Yankee was appropriate to assure minor issues were adequately addressed and corrected. Communication issues were addressed and Maine Yankee personnel responsible to monitor the site characterization were assigned. Issues identified by outside parties and agencies were being documented and addressed. Environmental sampling was being conducted in accordance with the procedures.

M8 Miscellaneous Maintenance Issues (92902)

M8.1 (Closed) LER 94-015-00, Secondary Component Cooling System Outside Design Basis Due to an Inoperable Non-Safeguards Isolation Trip Valve

During testing, Maine Yankee identified a faulty switch causing the secondary component cooling (SCC) non-safeguards isolation trip valve to fail. In the decommissioning mode of operation, the SCC non-safeguards isolation trip valve no longer provides a safety function. This LER is closed.

III. Engineering

E2 Engineering Support of Facilities and Equipment

E2.1 Spent Fuel Pool Heat-Up Testing

a. Inspection Scope (86700)

On October 22, 1997, Maine Yankee commenced a test of the spent fuel pool heat-up rate. The inspector reviewed the procedure, 4-17-23, Spent Fuel Pool Heat-Up Rate Test, and observed portions of the testing.

b. Observations and Findings

Procedure 4-17-23, Spent Fuel Pool Heat-Up Rate Test, was developed by Maine Yankee to characterize the heat-up rate of the spent fuel pool. This information will then be used as the bases for several engineering evaluations, such as the spent fuel pool island cooling system design and modifications to the emergency plan.

The procedure had two phases, the first being the securing of all spent fuel pool cooling and flow and monitoring the heat-up rate. During this phase pool temperature went from 81° F to 140° F over a period of 73 hours. During this phase the fuel building ventilation system was kept in service. Data recorded included pool temperature and level, and indoor and outdoor temperatures and humidities.

The second phase of the test maintained the pool at constant temperature to measure the pool evaporation rate. This data was collected with the pool at 140° F, 130° F, 120° F, 110° F, and 100° F. Temperature and humidity data was again taken.

c. Conclusion

The spent fuel pool heat-up test was an appropriate verification of the spent fuel pool heat-up rate. The procedure was well written and was properly approved. The test was performed and data was recorded as required by the procedure.

E2.2 Core Material Specimen Surveillance Capsule Removal

a. Inspection Scope (71707)

To obtain information related to activation of the reactor vessel materials, Maine Yankee elected to pull one of the core material specimen surveillance capsules for analysis. The inspector reviewed procedure 13-26, Recovery of Irradiation Surveillance Capsule, and observed the evolution of pulling the capsule.

b. Observations and Findings

Pulling the capsule was tied to the critical path of activities as a prerequisite for setting the reactor head and for isolating the transfer canal from the refueling cavity to the spent fuel pool. This evolution was of significance because the surveillance capsule was highly activated and had a potential to cause significant radiation exposure if handled improperly. The capsules were installed inside the reactor vessel between the vessel wall and the core shroud. The capsules require a special long handled tool to be threaded onto the capsule to unlatch the built in locking mechanism and allow lifting of the specimen. The evolution was lead by an engineer from the reactor engineering group.

A pre-evolution brief was conducted with all of the participants in the evolution. Stressing the need to keep the surveillance capsule submerged at all times, the health physics staff discussed radiological concerns associated with the job, contamination

control requirements, and expected dose rates in the work area. The engineer discussed the general sequence of the procedure. However, details of the capsule latching mechanism and techniques for retrieval were not discussed.

During the first attempt to remove a capsule, the engineer failed to adequately follow the procedure which resulted in the capsule latching mechanism not being released. In this case the engineer failed to direct the threading of the tool onto the coupler until the resistance of the locking mechanism was met. At this point the procedure directed further threading of three and one third turns to unlatch the locking device. The personnel performing the evolution only threaded the tool onto the coupler three and one third turns total and attempted to remove the specimen. As a result, the lock remained engaged and the force limit was reached without removing the capsule. This error was identified by the inspector and the procedure was stopped and repeated.

However, during the second attempt the tool was threaded too far onto the coupler which caused the lock to over extend and prevent removal of the specimen. Attempts were made to remove two other specimens prior to stopping the evolution. However, the personnel were within the bounds of the procedure and did not apply excessive forces in attempts to remove the capsules.

After a discussion with the vendor and review of the drawings, the personnel were able to better understand the manipulation of the lock and the key indications they were feeling with the tool. The removal of a capsule was subsequently completed and transferred to the spent fuel pool without further complication.

c. Conclusion

A weak procedure, poor procedure adherence, and inadequate planning for the capsule removal resulted in the evolution taking over twice as long as required. However, due to the low dose rates in the work area the additional radiation exposure was not significant. The radiological controls and oversight implemented by health physics were excellent and resulted in the completion of the job with no exposure or contamination concerns.

E8 Miscellaneous Engineering Issues

E8.1 (Closed) LER 97-08-00, Inservice Inspection and Testing Deficiencies

LER 97-08-00, reported several deficiencies in the inservice inspection and testing program. These deficiencies called into question the operability of several components utilized to maintain the reactor in the cold shutdown condition. NRC inspection report 97-03, section O1.2 reviewed the specifics of this issue and the corrective actions taken. This issue is closed.

IV. Plant Support**R7 Quality Assurance in Radiological Protection and Chemistry Activities****R7.1 Quality Assurance Audit of Radiation Protection****a. Inspection Scope (40500)**

From October 2, 1997, through October 9, 1997, Maine Yankee quality assurance performed an audit of the radiation protection and radioactive waste programs. The inspector attended the audit team exit meeting and reviewed the audit report, MY-97-03/09.

b. Observations and Findings

This audit was initiated, in part, because Maine Yankee was concerned with weaknesses identified at the Haddam Neck plant in Connecticut. The audit was a good initiative in emphasizing the importance of the health physics department in a decommissioning environment.

The audit team identified twelve issues through the course of the audit. The issues were promptly addressed by health physics management. The issues were entered into the learning bank and apparent causes and corrective actions were developed.

Some of the more significant issues identified were inadequacies, inconsistencies, and omissions in procedures and weaknesses in implementing effective corrective actions. Procedure reviews and revisions were ongoing and were scheduled to be completed by the end of the year. The specific issues representing the lack of appropriate corrective actions were individually addressed by Maine Yankee. However, the issue of the Maine Yankee corrective action program remains an issue. In a separate audit, quality assurance determined that inadequacies in the corrective actions program was a site-wide issue. Maine Yankee initiated a process improvement team and is planning a new corrective actions program in January.

c. Conclusion

The audit of health physics was a notable effort by Maine Yankee to identify and prevent issues similar to those which occurred at a similar facility undergoing decommissioning. The audit was thorough and the issues were appropriately accepted for resolution.

P5 Staff Training and Qualification in Emergency Preparedness

P5.1 Emergency Preparedness (EP) Activities

a. Inspection Scope (82301)

As a result of the destaffing, significant changes in the key positions of the emergency response organization (ERO) have occurred. The inspector reviewed the staffing of the ERO and observed a training drill.

b. Observations and Findings

Maine Yankee's current ERO roster consists of two full emergency response teams and a third team for filling "key" positions only. The licensee is in the process of training individuals who will be replacing those ERO members that are in the process of retiring and have key positions. At this time, all but a few have completed the required training.

On October 15, 1997, the inspector observed a training drill that enabled the new members to practice and gain experience in preparation for their new ERO positions. The drill scenario featured a dropped fuel bundle which caused fuel damage and a leak in the spent fuel pool liner. The inspector determined that the scenario was appropriate for the current status of the plant. The emergency response facilities were staffed appropriately and the staff followed steps delineated in their emergency response plan and procedures. The inspector noted that the licensee met the objectives of the training exercise and no major deficiencies were identified.

c. Conclusion

The EP staff has been very dedicated in ensuring that Maine Yankee meets their staffing and training obligations and continue to meet the commitments made in their emergency plan and procedures. The NRC inspector noted that training drills were an effective tool for providing hands-on training and determining the effectiveness of the EP training process.

S1 Conduct of Security and Safeguards Activities

a. Inspection Scope

The security program was inspected during the period of October 20-23, 1997 to determine whether the security program, as implemented, met the licensee's commitments in the NRC-approved security plan (the Security Plan) and NRC regulatory requirements. Areas inspected included: management support and audits; alarm stations and communications; protected area detection aids; testing maintenance and compensatory measures; personnel access controls; and training and qualification.

b. Observations and Findings

A violation of NRC requirements was identified. The violation involved the licensee's failure to ensure that detection aids used to alert security force members (SFMs) posted in the assessment towers were being controlled and maintained as required by the Security Plan. Management support is ongoing as evidenced by adequate staffing levels and the security manager's position in the organizational structure provides a means for making senior management aware of programmatic needs. Audits were thorough and in-depth; alarm station operators were knowledgeable of their duties and responsibilities; and protected area detection aids were being tested and maintained in accordance with the Security Plan. Security training was being performed in accordance with the NRC-approved training and qualification (T&Q) plan and protected area access controls of personnel were being implemented in accordance with the Security Plan.

c. Conclusion

The inspectors determined that, except for the violation associated with the detection aids, the licensee was conducting its security and safeguards activities in a manner that protected public health and safety. The Security Program, as implemented, met the licensee's commitments and NRC requirements.

S2 Status of Security Facilities and Equipment

S2.1 Protected Area Detection Aids

a. Inspection Scope

The scope included conducting a physical inspection of the protected area intrusion detection systems (IDSs) to verify that the systems were functional, effective, and met licensee commitments.

b. Observations, Findings and Conclusion

On October 22, 1997, the inspectors observed licensee testing of the IDSs and determined they were functional and effective, and were installed and maintained as described in the Security Plan. However, it was determined based on discussions with licensee management, documentation reviews, and inspector's observations, that the licensee failed to ensure that the detection aids, used to alert officers in the assessment towers, were being maintained and controlled as required in the Security Plan.

Specifically, on October 10, 1997, an SFM circumvented the reset button associated with the audible alarm in one of the assessment positions. This action limited the ability of the officer to be alerted to an intrusion in the protected area. This degraded condition continued for approximately 6 hours. During this time period, 5 additional SFMs failed to perform a complete post turnover check. This is of particular concern

as the applicable procedure was revised as a corrective action resulting from the occurrence of similar events in 1991 and 1995. This is a violation of NRC requirements. **(VIO 50-309/97-08-01)**

S2.2 Alarm Stations and Communications

a. Inspection Scope

The scope included determining whether the Central Alarm Station (CAS) and Secondary Alarm Station (SAS) are: (1) equipped with appropriate alarm, surveillance, and communication capability, (2) continuously manned by operators, and (3) use independent and diverse systems so that no single act can remove the capability of detecting a threat and calling for assistance, or otherwise responding to the threat, as required by NRC regulations.

b. Observations and Findings

Observations of CAS and SAS operations verified that the alarm stations were equipped with the appropriate alarm, surveillance, and communication capabilities. Interviews with alarm station operators found them knowledgeable of their duties and responsibilities. The inspectors also verified through observations and interviews that the alarm station operators were not required to engage in activities that would interfere with the assessment and response functions, and that the licensee had exercised communication methods with the local law enforcement agencies as committed to in the Security Plan.

c. Conclusion

The alarm stations and communications met the licensee's Security Plan commitments and NRC requirements.

S2.3 Testing, Maintenance and Compensatory Measures

a. Inspection Scope

The scope included determining whether programs were implemented that will ensure the reliability of security related equipment, including proper installation, testing, and maintenance to replace defective or marginally effective equipment and to determine that when security-related equipment fails, the compensatory measures put in place are comparable to the effectiveness of the security system that existed prior to the failure.

b. Observations and Findings

The inspectors reviewed testing and maintenance records for security-related equipment and found that documentation was on file to demonstrate that the licensee was testing and maintaining systems and equipment as committed to in the Security

Plan. A priority status was being assigned to each work request and repairs were normally being completed within the same day a work request necessitating compensatory measures was generated. The inspectors also noted that the working relationship between security, maintenance, and the instrumentation and control departments was excellent as evidenced by no open work requests requiring compensatory measures. However, the inspector did determine that despite repeated failures of the weekly testing on the primary communication system in an assessment tower, no maintenance work request was issued by the security organization.

c. Conclusion

Documentation on file confirmed, that security equipment was being tested and maintained as required, with the exception of an assessment tower primary communication system. Repair work was timely and the use of compensatory measures was found to be appropriate and minimal

S5 Security and Safeguards Staff Training and Qualification

a. Inspection Scope

The scope included a determination as to whether members of the security organization were trained and qualified to perform each assigned security related job task or duty in accordance with the NRC-approved T&Q plan.

b. Observations and Findings

On October 22, 1997, the inspectors randomly selected and reviewed T&Q records for ten SFMs. Physical and firearms requalification records were inspected for armed SFMs and security supervisors. The inspectors found that the training had been conducted in accordance with the T&Q Plan and was properly documented. Additionally, the inspectors interviewed a number of SFMs to determine if they possessed the requisite knowledge and ability to carry out their assigned duties.

c. Conclusion

The inspectors determined that training had been conducted in accordance with the T&Q plan. Based on the SFMs responses to the inspectors' questions and observations, the training provided by the security training staff was considered effective.

S6 Security Organization and Administration

a. Inspection Scope

The scope included conducting a review of the level of management support for the licensee's physical security program.

b. Observations and Findings

Security management has ensured that the security program is adequately staffed. The inspectors reviewed the Security Manager's position in the organizational structure and reporting chain. The Security Manager reports to the Operations Director, who reports to the President of Maine Yankee Atomic Power Company.

c. Conclusion

Management support for the physical security program was determined to be adequate. No problems with the organizational structure that would be detrimental to the effective implementation of the security and safeguards programs were noted.

S7 Quality Assurance in Security and Safeguards Activities

S7.1 Audits

a. Inspection Scope

The scope included a review of the licensee's Quality Assurance (QA) report of the NRC-required security program audit to determine if the licensee's commitments as contained in the Security Plan were being satisfied.

b. Observations and Findings

The inspectors reviewed the 1997 QA audit of the security program, conducted September 8-11, 1997, (Audit No. 97-004). The audit was found to have been conducted in accordance with the Security Plan. To enhance the effectiveness of the audit, the audit team included an independent security specialist. The audit report identified 5 findings. Two of the findings were related to procedure compliance, two were related to procedural inconsistencies, and one finding addressed human errors related to the control, issuance, and handling of documents. The inspectors determined that the findings were not indicative of programmatic weaknesses.

However, the audit report identifies that a common factor related to all five findings was inattention to detail. This causal factor is consistent with inspectors observations previously identified in this report.

The inspectors determined that based on discussions with security management and a review of the responses to the findings the corrective actions were effective.

c. Conclusion

The review concluded that the audit was comprehensive in scope and depth, that the findings were reported to the appropriate levels of management, and that the audit program was being properly administered.

F4 Fire Protection Staff Knowledge and Performance**F4.1 Falsification of Fire Watch Logs (URI 50-309/97-05-07) Closed****a. Inspection Scope (71750)**

The inspector reviewed the investigation and corrective actions taken in response to the falsification of fire watch logs by a temporary Maine Yankee employee. The individual, who was assigned to conduct fire watches, had signed off on some area logs without actually making the required periodic rounds.

b. Observations and Findings

On May 28, 1997, Maine Yankee security personnel identified that an employee designated to conduct fire watches in various areas of the plant had not been conducting the watches. This was determined when a security officer advised security supervision that the individual had not been seen on rounds for some time. Reviews of fire watch patrol logs and individual security key card records revealed that at some times, the individual was not actually in some areas contrary to his signature in the logs for those areas. As a result of degraded fire seal barriers, Maine Yankee requires a roving fire watch to enter and inspect eighteen areas of the plant on an hourly basis.

As immediate corrective actions, plant support management instituted a review of fire watch records to verify that there were no obvious problems. They also conducted periodic checks of the fire watch areas to verify that personnel were conducting the required watches. The requirements and significance of conducting the fire watches was re-iterated to all individuals involved in fire watches. Maine Yankee expanded their scope of reviews to include all personnel involved with performing fire watches, in order to determine the extent of this discrepancy. As a result of these reviews, Maine Yankee determined that three of the four individuals assigned to perform fire watches had falsified their logs.

In response to the identification of the fire watch issues, Maine Yankee terminated the involved employees and placed the fire round responsibilities with security. These corrective actions eliminated the problems with falsification of logs; however, several subsequent issues such as missed or late rounds were identified. Maine Yankee addressed these issues through increased supervisory oversight and changes to the implementation and tracking process.

The inspector reviewed the fire protection plan and the compensatory action process. The inspector concluded that the Maine Yankee implementation of fire watches as compensatory actions was not being implemented through approved procedures as required by technical specifications. Technical specifications, section 5.8.2.f, required written procedures for fire protection program implementation. The Maine Yankee procedure, 19-5, Impairments to Fire Protection Systems, required compensatory measures to be established for impairments to fire protection plan fire

protection systems. However, the instructions for implementation of the roving fire watch program implemented by Maine Yankee were not documented by procedures. Instead, Maine Yankee used a training lesson plan and a series of memos to implement the program. The inspector concluded that the inappropriate falsification issues identified were a result of inadequate procedural guidance and inadequate supervisory oversight.

Maine Yankee acknowledged this lack of procedural guidance and was in the process of developing a procedure to cover the roving fire watch program.

c. Conclusion

The issue of falsification of fire watch rounds was determined to be a result of improper implementation of the fire protection plan by Maine Yankee. The lack of procedures for the implementation of compensatory fire watch rounds is a violation of NRC requirements. **(VIO 50-309/97-08-02). (URI 50-309/97-05-07 and VIO 95-15-01 are closed)**

F8 Miscellaneous Fire Protection Issues

F8.1 (Closed) LER 93-04-00, Inoperable Fire Door

LER 93-04-00, Inoperable Fire Door, resulted from changes in the ventilation system lineup that overpowered a fire door closing mechanism causing the door to hang open. Corrective actions included adding a precaution to the operations procedure for the ventilation systems. The inspector reviewed the control area ventilation procedure 1-12-3 and verified the precaution was still in place. Based on the review of the corrective actions and numerous tours indicating fire doors were properly shut, this item is closed.

V. Management Meetings

X1 Exit Meeting Summary

The senior resident inspector presented the inspection results to members of the licensee on December 9, 1997. The licensee acknowledged the findings presented.

The security inspectors met with licensee representatives at the conclusion of their inspection on October 23, 1997. At that time, the purpose and scope of the inspection were reviewed, and the preliminary findings were presented. The licensee acknowledged the preliminary inspection findings.

X3 Management Meeting Summary

September 11, 1997, Maine Yankee met with NRC representatives in Rockville, MD, regarding regulatory issues associated with spent fuel storage casks.

September 30, 1997, NRC and Maine Yankee held a press conference at the Maine Yankee corporate building in Brunswick, ME regarding decommissioning.

October 7, 1997, NRC held a public meeting with Maine Yankee at the Wiscasset Middle School to discuss the decommissioning process.

November 6, 1997, NRC held a public meeting with Maine Yankee at the Wiscasset High School to discuss the Maine Yankee Post Shutdown Activities Report.

November 20, 1997, Maine Yankee met with NRC representatives in Rockville, MD, to discuss a recently submitted request for changes to the technical specifications.

November 25, 1997, Maine Yankee met with NRC representatives in Rockville, MD, to discuss proposed revisions to the emergency plan and review a related relief request.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

W. Odell, Director, Operations
G. Leitch, VP, Operations
R. Fraser, VP, Engineering
M. Meisner, VP, Nuclear Safety and Regulatory Affairs
B. Plummer, Operations Manager
J. Sauger, Maintenance Manager
E. Soule, Systems Engineering Manager
W. Ball, Assistant Manager, Operations Support
G. Zinke, Quality Programs Manager
J. Hebert, Regulatory Affairs Manager
Herb Torberg, Security Director
Carl Urquhart, American Protective Services (APS)
V. Cumming, Training Coordinator, APS

Other

P. Dostie, Maine, Nuclear Safety Inspector

INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering
 IP 40500: Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems
 IP 60705: Preparation for Refueling
 IP 60710: Refueling
 IP 61726: Surveillance Observation
 IP 62707: Maintenance Observation
 IP 71707: Plant Operations
 IP 71750: Plant Support
 IP 81700: Physical Security Program for Power Reactors
 IP 81070: Access Control - Personnel
 IP 92700: Onsite Followup of Written Reports of Nonroutine Events at Power Reactor Facilities
 IP 92901: Followup - Operations
 IP 92902: Followup - Maintenance
 IP 92903: Followup - Engineering
 IP 92904: Followup - Plant Support
 IP 93702: Prompt Onsite Response to Events at Operating Power Reactors

ITEMS OPENED, CLOSED, AND DISCUSSED

Items Opened:

50-309/97-08-01	VIO	Maintenance and Control of Protected Area Detection Aids contrary to the Security Plan. (Section S2.1)
50-309/97-08-02	VIO	Falsification of Fire Watch Logs contrary to the Fire Protection Plan. (Section F4.1)

Items Closed:

50-309/97-05-00	LER	Potential for Intake Structure Freezing Due to Loss of Power. (Section O2.1)
50-309/94-04-01	URI	Erosion Corrosion Database Deleted. (Section O8.1)
50-309/94-14-02	URI	MOV Pressure Locking and Thermobinding. (Section O8.1)
50-309/95-01-02	URI	Inoperable Fire Protection Ventilation Dampers. (Section O8.1)
50-309/95-07-02	URI	Potential Overpressurization of CCW System. (Section O8.1)

50-309/95-10-01	VIO	Design Control Weaknesses. (Section 08.1)
50-309/95-12-01	URI	Control Room HVAC Filter Flow Surveillance Testing. (Section 08.1)
50-309/95-12-02	URI	Evaluation of Freon Relief Valves Near Breathing Air Suction. (Section 08.1)
50-309/95-02-00	LER	Cracked CAM Followers in General Electric SBM Switches. (Section 08.1)
50-309/96-05-01	VIO	Design Basis Documentation not Maintained up-to-date. (Section 08.1)
50-309/96-08-03	URI	Emergency Diesel Generator Room Damper Tornado Design. (Section 08.1)
50-309/96-12-03	IFI	Documentation of Air Balance Surveillance Testing. (Section 08.1)
50-309/96-14-02	URI	Testing of HPSI Pumps and Valves. (Section 08.1)
50-309/96-14-04	URI	Safety-Related Logic Circuit Testing Update. (Section 08.1)
50-309/96-16-01	URI	Technical Specification Interpretations. (Section 08.1)
50-309/96-16-02	URI	Post Trip Reviews. (Section 08.1)
50-309/96-16-03	URI	Emergency Operation Procedures. (Section 08.1)
50-309/96-16-05	URI	Standby Power Meters not Calibrated and Periodically Tested. (Section 08.1)
50-309/96-16-07	URI	Containment Cleanliness After Outage. (Section 08.1)
50-309/96-16-08	URI	SER Conditions Satisfied but not Documented. (Section 08.1)
50-309/96-16-09	URI	MSL Rupture Analysis Errors and Inconsistencies. (Section 08.1)
50-309/96-16-10	URI	Lack of a Documented Process to Demonstrate Code Capability. (Section 08.1)
50-309/96-16-11	URI	CS System and the CCW Systems. (Section 08.1)
50-309/96-16-12	URI	CCW and RHR Heat Exchanger. (Section 08.1)

50-309/96-16-13	URI	RHR Heat Exchanger Thermal Transient. (Section O8.1)
50-309/96-16-14	URI	Electrical Calculations for EDG. (Section O8.1)
50-309/96-16-15	URI	EQ Issues. (Section O8.1)
50-309/96-16-16	URI	FSAR Discrepancies. (Section O8.1)
50-309/96-16-17	URI	Reportability of CCW Operations Different than FSAR Design. (Section O8.1)
50-309/96-16-20	URI	Emergency Diesel Generator Electrical Loading. (Section O8.1)
50-309/96-16-24	URI	Control Room Ventilation Testing Deficiency. (Section O8.1)
50-309/96-16-25	URI	Weaknesses in the Erosion/Corrosion Program. (Section O8.1)
50-309/95-17-00	LER	LSI-S-63 Leaking from Inlet Flange. (Section O8.1)
50-309/96-05-00	LER	PAB Masonry Wall Seismic Deficiency. (Section O8.1)
50-309/95-11-01	LER	Seat Ring Degradation in Contromatics Butterfly Valves. (Section O8.1)
50-309/96-16-00	LER	Failure to Maintain Short Term Corrective Action. (Section O8.1)
50-309/96-19-00	LER	SCC Standby Pump Autostart Pressure Switch Inoperable. (Section O8.1)
50-309/96-22-00	LER	Containment PCC Piping Design Inadequate. (Section O8.1)
50-309/96-23-00	LER	RWST Level Transmitter Uncertain Qualified Life. (Section O8.1)
50-309/96-25-00	LER	RCS Emergency Vent Valves Inoperable. (Section O8.1)
50-309/96-26-00	LER	EQ of Cables/Connectors Inside CTMT May Not Meet Requirements. (Section O8.1)
50-309/96-27-00	LER	FN-44 A&B Declared Inoperable. (Section O8.1)
50-309/96-28-00	LER	Inadequate Emergency Feedwater Pump Check Valve Surveillance. (Section O8.1)
50-309/96-20-00	LER	High Pressure Safety Injection Pump Auto-Start Wire Found Cut. (Section O8.1)

50-309/96-31-00	LER	Plant Trip During Reactor Protection System Surveillance. (Section 08.1)
50-309/96-34-00	LER	Inadequate Cable Separation For Post Accident Hydrogen Monitors. (Section 08.1)
50-309/96-36-00	LER	Entry into 3.0.A When Exhaust Fan Shut Down. (Section 08.1)
50-309/97-02-01	IFI	Revised Separation Criteria. (Section 08.1)
50-309/97-05-03	VIO	Failure to Reestablish Pump Baseline Values. (Section 08.1)
50-309/97-05-04	VIO	Test Control - Incorrect Acceptance Criteria. (Section 08.1)
50-309/97-05-05	VIO	Implementation of Code Alternative Without NRC Approval. (Section 08.1)
50-309/96-42-00	LER	Lack of Thermal Relief Valves for Several Heat Exchangers. (Section 08.1)
50-309/96-39-00	LER	Both Emergency Diesel Generators Declared Inoperable. (Section 08.1)
50-309/96-40-00	LER	Inadequate Surveillance Procedure for RTB Actuation. (Section 08.1)
50-309/96-43-00	LER	Generic Letter 96-01 Identified Surveillance Issues. (Section 08.1)
50-309/97-02-00	LER	PCC/SCC Vacuum Relief Valve Testing. (Section 08.1)
50-309/97-03-00	LER	Leaking Fuel Pins Identified in Westinghouse Fuel Assemblies. (Section 08.1)
50-309/97-04-00	LER	RCS Loop Fill Header MOV Overpressure. (Section 08.1)
50-309/97-10-00	LER	Steam Generator Tube Deficiency Issues. (Section 08.1)
50-309/96-43-01	LER	GL 9601 Testing Issues. (Section 08.1)
50-309/97-05-07	URI	Failure to Meet Requirements of 10 CFR 70.24 for New Fuel Criticality Monitors (Section 08.2)
50-309/93-08-00	LER	ECCS Valves Found Unlocked. (Section 08.3)
50-309/93-10-00	LER	Surveillance Testing of ECCS Subcomponents. (Section 08.1)

50-309/93-12-00	LER	Control Room Ventilation Trains Inoperable Due to Preventative Maintenance. (Section O8.4)
50-309/97-01-01	IFI	Spill of 1300 Gallons Through Pump Packing. (Section O8.5)
50-309/94-15-00	LER	SCC System Outside Design Basis Due to an Inoperable Non-Safeguards Isolation Trip Valve. (Section M8.1)
50-309/97-08-00	LER	Inservice Inspection and Testing Deficiencies. (Section E8.1)
50-309/97-05-07	URI	Falsification of Fire Watch Logs. (Section F4.1)
50-309/95-15-01	VIO	Inadequate Fire Program Procedures. (Section F4.1)
50-309/93-04-00	LER	Inoperable Fire Door (Section F8.1)

LIST OF ACRONYMS USED

CAS	Central Alarm System
CFR	Code of Federal Regulations
ECCS	Emergency Core Cooling System
ERO	Emergency Response Organization
GPS	Global Positioning System
ICI	Incore Instruments
LER	Licensee Event Report
MYAPS	Maine Yankee Atomic Power Station
NRC	Nuclear Regulatory Commission
PDR	Public Document Room
PIDS	Perimeter Intrusion Detection System
QA	Quality Assurance
SAS	Secondary Alarm System
SCC	Secondary Component Cooling
SFM	Security Force Members
SNM	Special Nuclear Material
T&Q	Training and Qualification
TVA	Tennessee Valley Authority
URI	Unresolved Issue
VIO	Violation